

CHECKLIST FOR INPROCESSING OF GOLDBAR LIEUTENANTS

- ___ Orders & DDF 1610 (**5 Copies**)
- ___ DD Form 2058 – State of Legal Residence
- ___ W-4 Form – Withholding Allowance Certificate
- ___ DA Form 5960 – BAH
- ___ ATZK-RM Form 3564 – Uniform Allowance
- ___ SF1199A – Direct Deposit (**Signed by Financial Institution**)
- ___ DA Form 3685 – Jumps Pay Election
- ___ Request for advance pay (**Submit whether 2LT wants advance or not**)
- ___ DD Form 137 – Personnel Register Card
- ___ DA 3955- Change of Address Card
- ___ -
- ___ DD Form 93 – Record of Emergency Data (**Original, copy stays w/SM**)
- ___ SGLV 8296 – SGLI Election (**Original, copy stays w/SM**)

If you need assistance or have any questions, please contact SGT Cruz at Region HQs, (502) 624-1951 or email at cruzi@knox-rotc.army.mil

Form W-4 (2001)

Purpose. Complete Form W-4 so your employer can withhold the correct Federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7, and sign the form to validate it. Your exemption for 2001 expires February 18, 2002.

Note: You cannot claim exemption from withholding if (1) your income exceeds \$750 and includes more than \$250 of unearned income (e.g., interest and dividends) and (2) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on itemized deductions, certain credits, adjustments to

income, or two-earner/two-job situations. Complete all worksheets that apply. They will help you figure the number of withholding allowances you are entitled to claim. **However, you may claim fewer (or zero) allowances.**

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See line E below.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding? for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends,

consider making estimated tax payments using **Form 1040-ES**, Estimated Tax for Individuals. Otherwise, you may owe additional tax.

Two earners/two jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others.

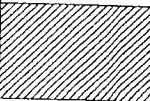
Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2001. Get Pub. 919 especially if you used the **Two-Earner/Two-Job Worksheet** on page 2 and your earnings exceed \$150,000 (Single) or \$200,000 (Married).

Recent name change? If your name on line 1 differs from that shown on your social security card, call 1-800-772-1213 for a new social security card.

Personal Allowances Worksheet (Keep for your records.)

- A** Enter "1" for **yourself** if no one else can claim you as a dependent **A** _____
- B** Enter "1" if: {
 - You are single and have only one job; or
 - You are married, have only one job, and your spouse does not work; or
 - Your wages from a second job or your spouse's wages (or the total of both) are \$1,000 or less. } **B** _____
- C** Enter "1" for your **spouse**. But, you may choose to enter -0- if you are married and have either a working spouse or more than one job. (Entering -0- may help you avoid having too little tax withheld.) **C** _____
- D** Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return **D** _____
- E** Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) **E** _____
- F** Enter "1" if you have at least \$1,500 of **child or dependent care expenses** for which you plan to claim a credit **F** _____
- (Note: Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)**
- G** **Child Tax Credit** (including additional child tax credit):
- If your total income will be between \$18,000 and \$50,000 (\$23,000 and \$63,000 if married), enter "1" for each eligible child.
 - If your total income will be between \$50,000 and \$80,000 (\$63,000 and \$115,000 if married), enter "1" if you have two eligible children, enter "2" if you have three or four eligible children, or enter "3" if you have five or more eligible children. **G** _____
- H** Add lines A through G and enter total here. **(Note: This may be different from the number of exemptions you claim on your tax return.)** ► **H** _____
- For accuracy, complete all worksheets that apply. {
 - If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
 - If you are **single**, have **more than one job** and your combined earnings from all jobs exceed \$35,000, or if you are **married** and have a **working spouse or more than one job** and the combined earnings from all jobs exceed \$60,000, see the **Two-Earner/Two-Job Worksheet** on page 2 to avoid having too little tax withheld.
 - If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Cut here and give Form W-4 to your employer. Keep the top part for your records.

Form W-4 Department of the Treasury Internal Revenue Service		Employee's Withholding Allowance Certificate		OMB No. 1545-0010 2001	
► For Privacy Act and Paperwork Reduction Act Notice, see page 2.					
1 Type or print your first name and middle initial		Last name		2 Your social security number	
Home address (number and street or rural route)				3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <small>Note: If married, but legally separated, or spouse is a nonresident alien, check the Single box.</small>	
City or town, state, and ZIP code				4 If your last name differs from that on your social security card, check here. You must call 1-800-772-1213 for a new card. <input type="checkbox"/>	
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)				5	
6 Additional amount, if any, you want withheld from each paycheck				6 \$	
7 I claim exemption from withholding for 2001, and I certify that I meet both of the following conditions for exemption: • Last year I had a right to a refund of all Federal income tax withheld because I had no tax liability and • This year I expect a refund of all Federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here					
Under penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate, or I am entitled to claim exempt status.				7	
Employee's signature (Form is not valid unless you sign it.) ►				Date ►	
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)				9 Office code (optional)	
				10 Employer identification number	

STATE OF LEGAL RESIDENCE CERTIFICATE

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Tax Reform Act of 1976, Public Law 94-455.

PURPOSE: Information is required for determining the correct State of legal residence for purposes of withholding State income taxes from military pay.

ROUTINE USES: Information herein will be furnished State authorities and to Members of Congress.

MANDATORY OR VOLUNTARY DISCLOSURE: Disclosure is voluntary. If not provided, State income taxes will be withheld based on the tax laws of the State previously certified as your legal residence, or in the absence of a prior certification, the tax laws of the applicable State based on your home of record.

NAME (Last, first, middle initial)

SOCIAL SECURITY NUMBER (SSN)

LEGAL RESIDENCE/DOMICILE (City or county and State)

INSTRUCTIONS FOR CERTIFICATION OF STATE OF LEGAL RESIDENCE

The purpose of this certificate is to obtain information with respect to your legal residence/domicile for the purpose of determining the State for which income taxes are to be withheld from your "wages" as defined by Section 3401(a) of the Internal Revenue Code of 1954. PLEASE READ INSTRUCTIONS CAREFULLY BEFORE SIGNING.

The terms "legal residence" and "domicile" are essentially interchangeable. In brief, they are used to denote that place where you have your permanent home and to which, whenever you are absent, you have the intention of returning. The Soldiers' and Sailors' Civil Relief Act protects your military pay from the income taxes of the State in which you reside by reason of military orders unless that is also your legal residence/domicile. The Act further provides that no change in your State of legal residence/domicile will occur solely as a result of your being ordered to a new duty station.

You should not confuse the State which is your "home of record" with your State of legal residence/domicile. Your "home of record" is used for fixing travel and transportation allowances. A "home of record" must be changed if it was erroneously or fraudulently recorded initially.

Enlisted members may change their "home of record" at the time they sign a new enlistment contract. Officers may not change their "home of record" except to correct an error, or after a break in service. The State which is your "home of record" may be your State of legal residence/domicile only if it meets certain criteria.

The formula for changing your State of legal residence/domicile is simply stated as follows: physical presence in the new State with the simultaneous intent of making it your permanent home and abandonment of the old State of legal residence/domicile. In most cases, you must actually reside in the new State at the time you form the intent to make it your permanent home. Such intent must be clearly indicated. Your intent to make the new State your permanent home may be indicated by certain actions such as: (1) registering to vote; (2) purchasing residential property or an unimproved residential lot; (3) titling and registering your automobile(s); (4) notifying the State of your previous legal residence/domicile of the change in your State of legal residence/domicile; and (5) preparing a new last will and testament which indicates your new State of legal residence/domicile. Finally, you must comply with the applicable tax laws of the State which is your new legal residence/domicile.

Generally, unless these steps have been taken, it is doubtful that your State of legal residence/domicile has changed. Failure to resolve any doubts as to your State of legal residence/domicile may adversely impact on certain legal privileges which depend upon legal residence/domicile including among others, eligibility for resident tuition rates at State universities, eligibility to vote or be a candidate for public office, and eligibility for various welfare benefits. If you have any doubt with regard to your State of legal residence/domicile, you are advised to see your Legal Assistance Officer (JAG Representative) for advice prior to completing this form.

I certify that, to the best of my knowledge and belief, I have met all the requirements for legal residence/domicile in the State claimed above and that the information provided is correct.

I understand that the tax authorities of my former State of legal residence/domicile will be notified of this certificate.

SIGNATURE

CURRENT MAILING ADDRESS (Include ZIP Code)

DATE

AUTHORIZATION TO START, STOP, OR CHANGE BASIC ALLOWANCE FOR QUARTERS (BAQ), AND/OR VARIABLE HOUSING ALLOWANCE (VHA)

For use of this form, see 37-104-3; the proponent agency is ASA (FM)

PRIVACY ACT STATEMENT

AUTHORITY:

37 USC 403; Public Law 96-343; EO 9397.

PRINCIPLE PURPOSE:

To start, adjust or terminate military member's entitlement to basic allowance for quarters (BAQ) and/or variable housing allowance (VHA).

ROUTINE USE:

To adjust member's military pay record, information may be disclosed to Army components, such as USAFAC, major commands, and other Army installations; to other DOD components; other federal agencies such as IRS, Social Security Administration and VA, GAO, members of Congress; State and local government; US and State courts, and various law enforcement agencies. Social Security Number (SSN) is used for positive identification.

DISCLOSURE IS VOLUNTARY:

Nondisclosure may result in nonpayment of BAQ and/or VHA. Disclosure of your SSN is voluntary. However, this form will not be processed without your SSN because the Army identifies you for pay purposes by your SSN.

1. NAME (Last, First, MI)

2. SOCIAL SECURITY NUMBER

3. GRADE

4. TYPE OF ACTION

START	CANCEL	CHANGE	REPORT
CORRECT	STOP	RECERTIFICATION	

5. DUTY LOCATION (Include Station, Name, City, State, and Zip Code)

6. DATE(ACTION
(YYMMDD))

7. BAQ TYPE

WITH DEPENDENTS

PARTIAL

WITHOUT DEPENDENTS

8. MARTIAL/DEPENDENCY STATUS

a. SINGLE	b. MARRIED (see blocks (1), (2) & (3))	c. DIVORCED (see blocks (1), (2) & (3))
d. LEGALLY SEPARATED (see blocks (1), (2) & (3))	e. DEPENDENT CHILD (see blocks (4), (5) & (6))	

9. QUARTERS ASSIGNMENT/AVAILABILITY

a. ADEQUATE (see block (1))	b. INADEQUATE (see blocks (1), (2) & (4))
c. TRANSIENT (see block (3))	d. NOT AVAILABLE

(1) Spouse/Former Spouse SSN	(2) Spouse/Former Spouse Duty Station	(3) Date of Marriage, Divorce/Separation
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(1) QUARTERS NO. _____	(2) FAIR RENTAL VALUE \$ _____
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(4) Child in Custody of:	Member	Spouse	Former Spouse	Other
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(3) FROM: _____ TO: _____

(5) If you check "OTHER" above, prepare DD Form 137 to establish dependency.

(6) If child support received from another military member, complete (1), (2) & (3).

(4) ☐ MEMBER ELECTION
(Member in grade E7 and ☐ COMMANDER DETERMINATION

10. DEPENDENTS/SHARERS (Continue on back if required)

NAME OF DEPENDENT/SHARER	COMPLETE CURRENT ADDRESS (Include ZIP Code)	RELATIONSHIP	DOB OF CHILDREN

11. CERTIFICATION OF DEPENDENT SUPPORT

I certify that I provide, or am will to provide adequate support for the above named dependents. I am aware that failure to support the above named dependents may result in stopping BAQ and recouping BAQ for any prior periods/nonsupport.

IAW service regulations, I certify that the dependency status of my primary dependents, on whose behalf I am receiving BAQ, has not changed so as to affect my entitlement thereto for the period

12. EXPENSES, IF AUTHORIZED, I AM REQUESTING VHA BASED ON

My permanent duty station:	My dependent's location:	Both my permanent duty station and dependent's location.
a. Monthly Expenses:	Member	Dependent
(1) Mortgage (PITI) or Rent		
(2) Insurance		
(3) Other		
TOTALS		
b. Sharer/Lease Information	c. Address Information	
(1) Rental/Residential Address:	(1) Landlord's Name and Address:	
(2) Effective Date:	(3) Expiration Date:	(2) Landlord's Phone No.
(4) Number of Sharers (show name(s) and address in block 10.)		

I certify ALL information regarding this authorization is correct. I will immediately notify the FAO/HRO of any changes in the information above, due to divorce, marriage, death, living in government quarters etc, which could affect by BAQ or VHA entitlement.

IMPORTANT: Making a false statement or claim against the US Government is punishable by courts martial. The penalty for willfully making a false claim or a false statement in connection with claims is a maximum fine of \$10,000 or imprisonment for 5 years, or both.

13. MEMBER'S SIGNATURE

14. DATE

15. CERTIFYING OFFICER'S SIGNATURE

16. DATE

DATA REQUIRED BY THE PRIVACY ACT 1974

1. Authority: Section 3687, Title 10, U.S. Code
2. Principal Purpose(s): Provides a basis for reimbursement of an individual's uniform allowance upon entry on active duty.
3. Routine Use: Establishment of individual's entitlement to the allowance and ultimately to pay him/her this entitlement.
4. Mandatory or voluntary disclosure and effect on the individual not providing information:
Mandatory. Noncompliance may result in delay or denial of payment of uniform allowance.

UNIFORM ALLOWANCE STATEMENT		
INSTRUCTIONS: Read the statement on the reverse side carefully. Enter complete information in the section(s) below. This is the basis for your claim. Type or print clearly. Sign all copies and submit in quadruplicate to Finance.		
I request reimbursement for uniform allowance as provided in Chapter XXX, DODFMR Volume 7A. Specifically: (Check the block on which entitlement is based.)		
Initial Uniform Allowance – Completion of 14 days AD or ADT Active Duty Uniform Allowance		Initial Uniform Allowance AD in excess of 90 days
SECTION I – INITIAL UNIFORM ALLOWANCE – Completion of 14 days AD or ADT		
Enter inclusive dates during which not less than 14 days of AD or ADT were performed:		
From:		To:
SECTION II – INITIAL UNIFORM ALLOWANCE – AD in excess of 90 days		
1. Status immediately prior to entry on active duty:		
2. Date of final type physical examination:		
3. Date reported for AD in excess of 90 days:		
4. Cite complete authority (Issuing HQ, date of orders, etc):		
SECTION III – ACTIVE DUTY UNIFORM ALLOWANCE		
1. Date of final type physical examination	2. Date reported for AD for an indefinite period in excess of 90 days:	3. Cite complete authority (Issuing HQ, date of orders, etc):
Signature		Date
Printed Name		SSN

JUMPS - JSS PAY ELECTIONS

For use of this form, see AR 37-104-3; the proponent agency is ASA(FM)

PRIVACY ACT STATEMENT

Authority: Title 37 USC, Section 101.
Principal Purpose: To provide the service member a means of electing the manner in which he or she desires to receive pay and allowances.
Routine Use: To establish the pay account of the MMPPF.
Disclosure: Disclosure of your social security number (SSN) and other personal information is voluntary; however, without the requested information, the Finance Office cannot identify members, or take the requested action.

1. HOW DO YOU WANT TO BE PAID? (X one item.)

- a. Once a Month
b. Twice a Month

2. METHOD OF PAYMENT (X one item.)

- a. Sure Pay/Direct Deposit (Complete Section 4.)
b. Check to Address (Complete 5.)

3. HELD PAY (NOTE: All amounts may be withdrawn at any time upon application to your Finance Officer.)

- a. If a held pay amount is also desired, check box and enter amount.

b. SPECIFY AMOUNT

\$

4. SURE PAY/DIRECT DEPOSIT (X one box.)

- a. SF 1199A attached. (Complete items (1) through (5)).

- b. SF 1199A on file. (Use this box if you already have SURE PAY/DIRECT DEPOSIT to this financial institution) (Do not complete items (1) through (5)).

(1) NAME OF FINANCIAL ORGANIZATION

(2) SAVINGS OR CHECKING ACCOUNT NO

(3) NAME OF ACCOUNT HOLDER

(4) STREET NO., RR NO., P.O. BOX

(5) CITY, STATE, ZIP CODE (Or Country)

5. CHECK TO ADDRESS (Provide complete mailing address.)

a. STREET NO., RR NO., P.O. BOX

b. CITY

c. STATE

d. ZIP CODE

e. COUNTRY

6. REMARKS

7. I HEREBY AUTHORIZE PAYMENT AS SPECIFIED ABOVE.

a. TYPED OR PRINTED NAME

e. NAME AND ADDRESS OF ORGANIZATION

b. SSN

c. SIGNATURE

d. DATE

NAME: _____ SSAN: _____ RANK: _____
Print LAST, FIRST, MI

() I do not elect to receive an advance pay.

[illegible]

Updated version
March 2004

PERSONNEL REGISTER						
For use of this form, see AR 600-8-6; the proponent agency is ODCSPER						
NAME			ORGANIZATION			
SIGNATURE			SOCIAL SECURITY NUMBER			GRADE
DATE	ACTION		REASON			
	IN	OUT	LEAVE	TDY	PCS	OTHER
TIME						
REMARKS						

PRINT NAME (Last, First, MI)		GRADE	SSN	PURGE DATA
NEW ORGANIZATION (Complete Designation)				BOX NUMBER
<p>DATA REQUIRED BY THE PRIVACY ACT OF 1974. AUTHORITY: Title 39 USC and DOD/Postal Service Agreement, 2 Feb. 59. PRINCIPAL PURPOSE: To route and forward (Directory) mail. ROUTINE USES: Used by Army military and civilian personnel in mail functions and address inquiries. Data are inspected by commanders, postal officers, and military and civilian inspectors. DISCLOSURE: Voluntary. However, failure to provide the requested information could result in delay/inability to forward mail.</p>				
OLD MAILING ADDRESS (Include BOX No., if any, and ZIP Code)		NEW MAILING ADDRESS (Include ZIP Code)		
DATE DEPARTED OLD ORG:		DATE DUE NEW ORG:		
QUARTERS/OFF POST ADDRESS		REMARKS		
CONSENT: <input type="checkbox"/> I DO <input type="checkbox"/> I DO NOT CONSENT TO RELEASE THE ABOVE HOME ADDRESS OR SSN TO THIRD PARTIES.		(IF DEPARTING, COMPLETE BELOW ITEMS)		
		HEADQUARTERS ISSUING ORDERS		
SIGNATURE	DATE	ORDER NUMBER	ORDER DATE	

DA FORM 1 FEB 79 **3955** EDITION OF 1 AUG 78 MAY BE USED.

CHANGE OF ADDRESS AND DIRECTORY CARD
 For use of this form, see AR 600-8-3, the proponent agency is ODCSPER

Completely
filled out

RECORD OF EMERGENCY DATA

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 1475 to 1480 and 2771, 38 USC 1970, 44 USC 3101, and EO 9397, November 1943 (SSN).

PRINCIPAL PURPOSES: This form is used to designate beneficiaries for certain benefits in the event of the servicemember's death. It is a guide for the disposition of that member's pay and allowances if captured, missing or interned. It also shows names and addresses of the person(s) the servicemember desires to be notified in case of emergency or death. The purpose of soliciting the SSN is to provide positive identification.

ROUTINE USES: None.

DISCLOSURE: Voluntary; however, failure to provide personal identifier information may delay notification of the servicemember's status or may handicap processing of benefits to designated beneficiaries.

INSTRUCTIONS TO SERVICEMEMBER

This extremely important form is to be used by you to show the names and addresses of your spouse, children, parents, and any other person(s) you would like notified if you become a casualty, and, to designate beneficiaries for certain benefits if you die. IT IS YOUR RESPONSIBILITY to keep your Record of Emergency Data up to date to show your desires as to beneficiaries to receive certain death payments, and to show changes in your family or other dependents listed; for example, as a result of marriage, civil court action, death, or address change. Regarding your designation in Item 11, "Allotment if Missing" (if used by your Service), please read the following

statement carefully, and sign on the line provided:

I fully understand that, if I am captured, missing, or interned, my designation of allotments to dependents from my pay and allowances serves only as a guide to the Secretary of my Service. The Secretary may alter my designated allotment in the best interests of myself, my dependents, or the United States Government.

(Signature of Servicemember)

1. NAME <i>(Last, First, Middle)</i>		2a. SSN	b. INITIAL <i>(To indicate valid SSN)</i>	3a. SERVICE	b. REPORTING UNIT CODE DUTY STATION
4a. SPOUSE NAME		b. ADDRESS <i>(Include ZIP Code)</i>			
5. CHILDREN a. NAME		b. RELATIONSHIP	c. DATE OF BIRTH <i>(YYYYMMDD)</i>	d. ADDRESS <i>(Include ZIP Code)</i>	
6a. FATHER NAME		b. ADDRESS <i>(Include ZIP Code)</i>			
7a. MOTHER NAME		b. ADDRESS <i>(Include ZIP Code)</i>			
8a. DO NOT NOTIFY DUE TO ILL HEALTH		b. NOTIFY INSTEAD			
9a. BENEFICIARY(IES) FOR DG <i>(If no surviving spouse or child)</i>			b. ADDRESS <i>(Include ZIP Code)</i>		c. PERCENTAGE
10a. BENEFICIARY(IES) FOR UNPAID PAY/ ALLOWANCES			b. ADDRESS <i>(Include ZIP Code)</i>		c. PERCENTAGE
11. ALLOTMENT DESIGNEE/PERCENTAGE IF MISSING <i>(Subject to Secretarial determination)</i>					
12. INSURANCE <i>(SGLI and other Insurance Companies/Policy Numbers)</i>		a. SGLI <i>(Optional Service Use)</i> <input type="checkbox"/> MAXIMUM <input type="checkbox"/> NO <input type="checkbox"/> OTHER <i>(Amount)</i>		b. INSURANCE COMPANIES/POLICY NUMBERS	
13. CONTINUATION/REMARKS					
14. SIGNATURE OF SERVICEMEMBER <i>(Include rank, rate, or grade)</i>		15. SIGNATURE OF WITNESS <i>(Include rank, rate, or grade)</i>		16. DATE SIGNED <i>(YYYYMMDD)</i>	

INSTRUCTIONS FOR PREPARING DD FORM 93

(See appropriate Service Directives for supplemental instructions for completion of this form at other than MEPS)

All entries explained below are for electronic or typewriter completion, except those specifically noted. If computer or typewriter is not available, print in black or blue-black ink insuring a legible image on all copies. Include "Jr.," "Sr.," "III" or similar designation for each name, if applicable. When an address is entered, include the appropriate ZIP code. If the member cannot provide a current address, indicate "unknown" in the appropriate item. Addresses shown as P.O. Box Numbers or RFD numbers should indicate in Item 13, "Continuations", a street address or general guidance to reach the place of residence. In addition, the notation "See Item 13" should be included in the item pertaining to the particular next of kin. If the address for the person in the item has been shown in a preceding item, it is unnecessary to repeat the address; however, the name must be entered. When the space for a particular item is insufficient, insert "See #13" and continue the information in Item 13. Also see preparation instructions for Item 13.

ITEM 1. Member's full last name, first name, middle name.

ITEM 2a. Member's social security number (SSN).

ITEM 2b. Member's initials in ink, verifying SSN accuracy.

ITEM 3a. Service. Use standard one-letter Service code (A - Army, F - Air Force, N - Navy, M - Marine Corps).

ITEM 3b. Reporting Unit Code/Duty Station. Army/Air Force/Navy - see Service Directives. Marine Corps - MEPS enters Monitored Command Code (MCC) to which the member will be assigned.

ITEM 4. First name, middle initial, maiden name (if applicable), and address of spouse. If member is single, divorced, or widowed, so state.

ITEM 5. First name, middle initial, last name (only if different from member's), relationship to member, and date of birth of all children. If none, so state. Include illegitimate children if acknowledged by member or paternity/maternity has been judicially decreed. Indicate relationship, for example: 03 - son, 04 - daughter, 13 - stepson, 14 - stepdaughter, 33 - adopted daughter, 34 - adopted son. Sample entries: Mary A./04/19650704; Donald E. Jones/13/ 19630102. For children not living with the member's current spouse, include address and name and relationship of person with whom residing.

ITEM 6. First name, middle initial, last name, and address of father. If unknown or deceased, so state. Include civilian title or military grade if applicable. If other than natural father is listed, indicate relationship.

ITEM 7. First name, middle initial, last name, and address of mother. If unknown or deceased, so state. Include civilian title or military grade if applicable. If other than natural mother is listed, indicate relationship.

ITEM 8. Persons not to be notified due to ill health.

- a. List relationship, e.g., "Mother," of person(s) listed in Items 4, 5, 6, or 7 who are not to be notified of a casualty due to ill health. If more than one child, specify, e.g., "daughter Susan."
- b. List relationship, e.g., "Father" or name and address of person(s) to be notified in lieu of person(s) listed in item 8a.

ITEM 9. First name, last name, address, and relationship of person(s) to receive the 6 months' gratuity pay if there is no surviving spouse or child at the time of death. Only parents (including a person in loco parentis status) and brothers and sisters (including those of half-blood and those through adoption) may be designated. Loco Parentis means any person(s) who acted in place of the member's parent(s) for a period of not less than one year at any time before the member entered on active duty. If brothers or sisters are designated, show date of birth (YYYYMMDD).

Show percentage to be paid to each person if two or more beneficiaries are designated. The sum shares must equal 100 percent. If no percentage is indicated and more than one person is named, the money is paid in equal shares to the persons named. Enter "None" if the member has no eligible beneficiary. No benefit can be paid in that instance (10 USC 1477). Also enter "None" if the member does not wish to designate a beneficiary. Payment then is made in the order of precedence established by law. The member should make specific designation, however, as it expedites payment.

ITEM 10. First name, middle initial, last name, address and relationship of person(s) to receive unpaid pay and allowances at time of death. The member may indicate anyone to receive this payment. If member designated two or more beneficiaries, state the percentage to be paid for each. The sum shares must equal 100 percent. If the member does not wish to designate a beneficiary, enter "None." The member is urged to designate a beneficiary for unpaid pay and allowances as payment will be made to the person in the order of precedence established by law (10 USC 2771) in the absence of a designation.

ITEM 11. First name, middle initial, last name, relationship, and address of dependent(s) the member designates to receive an allotment of pay if missing, captured, or interned. This allotment may be initiated by the Service Secretary or his designee in the event the member enters a missing status. This item may be left blank. If member designates two or more allottees, state the percentage to be paid to each. The sum shares need not equal 100 percent, but may not exceed 100 percent. NOTE: Designations made in Item 11 are used as a guide by the Service Secretary or designee in establishing, changing, or discontinuing an allotment in the interest of the member (37 USC 551-558). The final decision rests with the Service Secretary or designee.

ITEM 12. Insurance information.

- a. Serviceman's Group Life Insurance (SGLI). Not applicable for Marine Corps and Air Force members. NOTE: Completion of this item does not constitute a SGLI election or designation or beneficiary(ies). Indicate, by entering an "X" in the appropriate block, the member's SGLI election (as stated in VA Form 29-8286). For Navy members, on the next line, enter, as appropriate, either: "Bene Desig filed (YYYYMMDD)," or "Bene Desig not filed."
- b. Insurance companies/policy numbers. Enter full name of all commercial life insurance companies to be notified in case of death. Enter policy number if member desires; this expedites settlement of claims.

ITEM 13. Continuations/remarks. Use this item for remarks or continuation of other items, if necessary. Prefix entry with the number of the item being continued; for example, 5/John J./03/ 19451220/321 Pecan Drive, Schertz TX 78151. Also use this item to list name, address, and relationship of other persons the member desires to be notified. Other dependents may also be listed.

ITEM 14. Member's signature. Have the member check and verify all entries and sign all copies in ink as follows: First name, middle initial, last name. Include rank, rate, or grade.

ITEM 15. Signature of witness. Have a witness (disinterested person) sign all copies in ink as follows: First name, middle initial, last name. Include rank, rate, or grade.

ITEM 16. Date the member signs the form. This item is an ink entry and must be completed by the member on four copies.

Directions To Personnel Clerks Of The Uniformed Services

1. Complete all appropriate items on this form. All entries except the signature and those requested to be in the servicemember's own handwriting, must be typed or printed in ink.
2. Include the name, address, and social security number (if available) of the beneficiary(ies), and the relationship of the beneficiary(ies) to the servicemember (e.g., father, sister).
3. If a servicemember wants to designate a beneficiary other than would be normal under his or her family circumstances, see "Unusual Beneficiary Designations" in the *Servicemen's Group Life Insurance Handbook*, Handbook 29-75-1.
4. An authorized agent of the Uniformed Service must witness the signature of the servicemember. This representative must sign his or her name below that of the servicemember and should include the date he or she received the form.
5. This form, properly completed, is authority to a payroll office to initiate or change the deductions for insurance premiums if the amount of insurance is changed or cancelled.
6. Inform the servicemember that if he has questions about this form, he or she may obtain the advice of a military attorney at no expense to the servicemember.
7. **After the form is completed in its entirety, you should:**
 - Make two photocopies of the completed form (page 2)
 - Distribute as follows

Original Copy (page 2) - Must be promptly filed in the official personnel file of the member

Photocopy 1 (page 2), **Directions to Servicemember** (page 3), and **Introduction to VA Benefits** (page 4) - To servicemember

Photocopy 2 (page 2) - To the Active or Reserve component of the Uniformed Service.

Note: Please do not send any of the forms or copies to the Office of Servicemembers' Group Life Insurance or to the Department of Veterans Affairs.

Please read the instructions before completing this form.

Servicemembers' Group Life Insurance Election and Certificate

Use this form to: (check all that apply)

- ☐ Name or update your beneficiary
☐ Reduce the amount of your insurance coverage
☐ Decline insurance coverage

Important: This form is for use by Active Duty and Reserve members. This form does not apply to and cannot be used for any other Government Life Insurance.

Last name

First name

Middle name

Rank, title, or grade

Social Security Number

Branch of Service (Do not abbreviate)

Current Duty Location

Amount of Insurance

By law, you are automatically insured for \$250,000. **If you want \$250,000 of insurance**, skip to *Beneficiary(ies) and Payment Options*. **If you want less than \$250,000 of insurance**, please check the appropriate block below and write the amount desired and your initials. Coverage is available in increments of \$10,000. **If you do not want any insurance**, check the appropriate block below and write (in your own handwriting), "I do not want insurance at this time."

☐ I want coverage in the amount of \$ _____ Your initials _____

☐ _____

(Write "I do not want insurance at this time.")

***Note:** Reduced or refused insurance can be *only* be restored by completing form SGLV 8285 with proof of good health and compliance with other requirements and will also affect the amount of VGLI you can convert to upon separation from service.

Beneficiary(ies) and Payment Options

I designate the following beneficiary(ies) to receive payment of my insurance proceeds. I understand that the principal beneficiary(ies) will receive payment upon my death. If all principal beneficiaries predecease me, the insurance will be paid to the contingent beneficiary(ies).

Complete Name (first, middle, last) and Address of each beneficiary	Social Security Number (if known)	Relationship to you	Share to each beneficiary (Use %, \$ amounts or fractions)	Payment Option (Lump sum or 36 equal monthly payments)
Principal				
1.				
2.				
Contingent				
1.				
2.				
3.				

I HAVE READ AND UNDERSTAND the instructions on pages 2 and 3 of this form. I ALSO UNDERSTAND that:

- **This form cancels any prior beneficiary or payment instructions.**
- The proceeds will be paid to beneficiaries as stated in #6 on page 3 of this form, unless otherwise stated above.
- If I have legal questions about this form, I may consult with a military attorney at no expense to me.
- I cannot have combined SGLI and VGLI coverages at the same time for more than \$250,000.

SIGN HERE IN INK



(Your signature. Do not print.)

Date: _____

Do not write in space below - For official use only.

WITNESSED AND RECEIVED BY:

RANK, TITLE, OR GRADE

ORGANIZATION

DATE RECEIVED

SGLV-8286, June 2001

SUPERSEDES AND REPLACES FORM SGLV 8286, March 2000 WHICH WILL NOT BE USED.

Original copy - Member's Official Personnel File
Photocopy 1 - To Member
Photocopy 2 - To Active or Reserve Component of Uniformed Service

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Directions To Servicemember

What You Should Know

This insurance is granted under the Servicemembers' Group Life Insurance provisions of Title 38, United States Code, and is subject to the provisions of that title and its amendments, and regulations promulgated thereto.

This form must be correctly completed, signed and received by your Uniformed Service before your death in order for this designation to be valid. An authorized agent of the Uniformed Services should witness your signature.

Periods of Coverage. This insurance is in effect throughout the period of full-time active duty or active duty for training. Coverage is also in effect on a full-time basis for reservists who are assigned to a unit or position in which they may be required to perform active duty or active duty for training and each year will be scheduled to perform at least 12 periods of inactive duty training that is creditable for retirement purposes under Chapter 67 of Title 10. Coverage continues for 120 days following separation or release.

Instructions On Completing This Form

1. Type or print in ink all items except where otherwise noted.

2. Naming Beneficiaries

- A. A new SGLV-8286 must be completed to change your beneficiary. You may name anyone as beneficiary without his/her knowledge or consent.
- B. If the beneficiary is a married woman, use her given first and middle names. For example, use Mary Lisa Smith, instead of Mrs. John Smith.
- C. A named beneficiary will **NOT** be changed automatically by any event occurring after you complete this form (e.g. marriage, divorce, etc.). Your beneficiary cannot be changed by, and is not affected by, any other documents such as a divorce decree or will.
- D. If you want to name more than two principal beneficiaries, or more than three contingent beneficiaries, list those beneficiaries on a separate sheet and write "See attached list" under the *Principal* or *Contingent* block. The separate sheet must contain your signature, social security number, and the date, and must be attached to this form.
- E. If you name minor children as beneficiaries, the insurance will be paid to the court-appointed guardian of the children's estate.
- F. You can establish a trust for the benefit of the children and name the trust as the beneficiary. A trust names a trustee of your choice to be legally responsible for administering the insurance proceeds for the children. Naming a trust as a beneficiary on this form does **NOT** create a trust. Before naming a trust as beneficiary, you should consult a military attorney for assistance.

3. Social Security Number - Do not delay completing this form if you do not have a beneficiary's social security number. The social security number helps us to locate the beneficiary, but is not necessary.

4. Shares to each beneficiary - If you name more than one beneficiary, the sum of the shares must equal 100%, or the full dollar amount of your insurance.

Example:	mother	\$125,000		50%	1/2
	<u>father</u>	<u>\$125,000</u>	or	<u>50%</u>	<u>1/2</u>
	Total	\$250,000		100%	1

5. Payment Option - You may choose whether you want the beneficiary to receive payment in one lump sum or in 36 equal monthly payments by writing "lump sum" or "36" in the column labeled *Payment Option*. If you choose 36 payments, the beneficiary cannot choose to receive a lump sum payment. If you want the beneficiary to have a choice at the time of payment, write "lump sum" or leave the block blank.

6. Provisions For Payment Of Insurance

- A. If you name more than one principal beneficiary and one or more predeceases you, the share(s) will be divided equally among the remaining principal beneficiaries, unless otherwise stated. If there are no surviving principal beneficiaries, the proceeds will be divided among the contingent beneficiaries.
- B. If you do not name a beneficiary, or if there are no surviving beneficiaries, or if you indicate that payment should be made *by law*, the proceeds will be paid in the following order:
 - 1. Widow or widower
 - 2. Children in equal shares (the share of any deceased child will be distributed equally among the descendants of that child)
 - 3. Parent(s) in equal shares or all to surviving parent
 - 4. A duly appointed executor or administrator of your estate
 - 5. Other next of kin

What Your Beneficiaries Should Know

Upon your death, your beneficiary(ies) should send a claim to the Office of Servicemembers' Group Life Insurance, 213 Washington Street, Newark, NJ 7102-2999. Your beneficiary may also call 1-800-419-1473 for claim information.